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THE JOURNAL OF CUTANEOUS DISEASES
INCLUDING SYPHILIS

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CONTENTS.

ORIGINAL COMMUNICATIONS.

Tropical Forms of Pityriasis Versicolor. Aldo Castellani, M. D..... 393
Note on Tinea Imbricata and its Treatment. Aldo Castellani, M. D..... 400
Tinea Intersecta. Aldo Castellani, M. D..... 404
Large Doses of Quinine in the Treatment of Dermatitis Exfoliativa. W. H. Mook, M. D. 407

SOCIETY TRANSACTIONS.

New York Dermatological Society, (April)..... 415
Case of Psoriasis of the palms,—A Case of Scleroderma,—Case of Lupus erythematosus of mucous membrane of lip,—Case of Lupus Erythematous,—Lupus Erythematosus of the Nodular Type,—Urticaria Pigmentosa,—Malingering,—Tuberculide,—Xeroderma Pigmentosum,—Case for Diagnosis,—Bromide Eruption,—Multiple Fibroma,—Case of Subcutaneous Abscesses from the Intramuscular Injections of Mercury,—Papillomatous Syphilide,—Leprosy,—Cornu Cutaneum of the Glans Penis.

Chicago Dermatological Society (April)..... 424
Case for Diagnosis,—Case of Nail Growth,—Three Cases of the Thin, Wide, Flat Finger Nails of Toxic Hyperidosis,—Acne,—Leukoplakia of Lower Lip,—Tinea Sycosis,—Lupus Erythematosus,—Mycosis Fungoides.

Manhattan Dermatological Society (January)..... 427
Chancre of Rectum,—Chancre of Rectum,—Tuberculosis Cutis Verrucosa,—Erythema Multiforme Tuberculatum and Acute Eczema.

New York Academy of Medicine, Section on Dermatology (April)..... 429
Two Cases of Telangiectases (Xeroderma Pigmentosum?),—Pityriasis Rubra Pilaris, Xanthoma Tuberosum,—Verruca Seborroica,—Pigmented Hairy Nævus (two cases),—Tuberculosis Cutis Treated by X-ray.

REVIEW OF DERMATOLOGY AND SYPHILIS.

Diseases of the Hair and Nails..... 435
Trichorrhexis nodosa, Etiology of,—*Adamson.* Alopecia areata, A new method of treatment in,—*McInerney.* Trichopathophobia,—*Mewborn.* Trichonodosis,—*McLeod.* Keratosis follicularis associated with alopecia areata,—*McLeod and Collins.* Trichorrhexis nodosa,—*Whitfield.* Onychomycosis,—*Colcott Fox.* Pigmentation of the nails in secondary syphilis,—*Vörner.* Alopecia, frontal band, as a possible sign of exophthalmic goitre and associated conditions,—*D. Walsh.* Hypertrichosis circumscriptum,—*Landau.* Trichonodosis,—*Otto Kren.*

OBITUARY.

Dr. Frank Hugh Montgomery..... 439

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXVI SEPTEMBER, 1908 NO. 9

TROPICAL FORMS OF PITYRIASIS VERSICOLOR

By Aldo Castellani, M. D.,

Director of the Clinic for Tropical Diseases, Colombo (Ceylon).

In the *British Medical Journal*, November 11, 1905, I published a preliminary note in which I stated that in the Tropics there are found several forms of pityriasis versicolor. I described two principal varieties, one yellow, under the name of pityriasis flava; the other black, under the name of pityriasis nigra. Further investigations have enabled me to confirm and enlarge these observations.

Pityriasis versicolor flava.—This is the commonest form, and in my opinion there are several sub-varieties of it. The affected parts are yellowish, of much lighter color than the surrounding healthy skin; the yellow color may be of various tinges, from dark, deep, orange-yellow in some cases, to very light canary-yellow in others. The patches are of various sizes; generally roundish, smooth, sharply defined, with margins not elevated, or only slightly so. Sometimes the patches are irregularly festooned, and may encircle areas of healthy skin. Occasionally the encircled healthy skin appears to be intersected by many yellowish, ribbon-like lines originating from the surrounding yellow patch. The regions most frequently affected are, in order of frequency, the face, neck, chest, and abdomen. Large portions of the body may be involved. There is no pruritus. The patches are not desquamating, or only very slightly so. The course of pityriasis flava is very chronic. In the natives of the lower classes it appears in childhood as tiny spots on the face and chest, spreading slowly during years; they may coalesce, covering practically the whole of the face and chest. One is occasionally surprised to see a native whose face and chest are quite light in color; on closer examination it may be found that this lighter appearance is due to a diffuse, very light-colored form of pityriasis flava, covering the whole of the face, neck and chest. In native women, when the patches of pityriasis flava are small, light, and situated on the face, they are considered as beauty spots, and are highly appreciated by the ladies and their admirers. Such

patches are called in Singhalese, "alu-hama," which means ashy skin (*alu*, ash, *hama*, skin). There is also another word used by native poets for such condition, "gomera," which means skin dotted with beauty spots.

The disease in Ceylon and India usually affects natives only (Singhalese, Tamils, etc.), more rarely Burghers. I have seen one case among Europeans. The patient has been in the Island for twenty years, and is a planter on a tea estate. He noticed the first light yellowish spots on the skin of the right arm six years ago; the eruption spread, slowly but continuously, to the neck and trunk; some spots are to be seen on the legs also. He has no pruritus whatever. The patient thinks he has been infected by some coolie affected with the disease.

Peculiar variety of pityriasis flava.—I have recently come across a peculiar variety of pityriasis flava characterized by a reddish-yellowish, or copper-colored tint. The fungus is microscopically indistinguishable from the fungus of the typical pityriasis flava, and cannot, likewise, be grown. I have seen several cases among natives of lighter complexion, and a most interesting one among Europeans. In the European the eruption was of four months' duration; he was sent to me with a diagnosis of seborrhœa corporis. The eruption was localized to the skin of the chest; numerous reddish spots, with perhaps a yellowish tinge, were present; some of which had coalesced in larger patches; no pruritus. The microscopical examination of scrapings from the eruption in liquor potassæ revealed the presence of a fungus microscopically identical with the fungus of pityriasis flava.

The fungus was very abundant.

Pityriasis versicolor alba.—This might perhaps be considered as a variety of pityriasis lutea. The color, however, is extremely light, occasionally altogether white; and the fungus found, as described later, is quite different from the one found in pityriasis lutea. Pityriasis alba is oftener seen on the arms and legs than on the face and chest. The patches are frequently slightly elevated and are not so smooth as those of pityriasis lutea generally are; a slight degree of very fine pityriasic white desquamation is often present. The fungus is very abundant. The infection in contrast to pityriasis flava is very easily cured with the ordinary antiparasitic substances.

Pityriasis versicolor nigra.—The affected parts are of a dull black, lusterless color, much darker than the surrounding dark,

PLATE XXXIV.—To Illustrate Dr. Aldo Castellani's Article, Tropical Forms of Pityriasis Versicolor.

Patient affected with Pityriasis Flava (face) and Pityriasis Nigra (neck).

healthy skin of the native. The patches may be small, roundish, and separated from each other, or may coalesce; the patches are often very slightly elevated, and may present a slight desquamation. Little, if any, pruritus is present. The face is not usually affected in this type of pityriasis, though the eruption may be found on practically any other region of the body. The neck and upper portion of the chest are apparently the regions most frequently affected. Pityriasis nigra usually attacks natives only. I have seen, however, an identical or similar form in a European. This European went for a pleasure trip to Burmah, where he remained for about a month. On coming back to Ceylon he noticed a small, roundish, very slightly elevated, non-desquamating black patch on the palm of his left hand. There was no pruritus. The patch spread slowly for two months, reaching the size of a sixpenny piece. It disappeared after a single application of formalin; three months later

Microsporon Tropicum (Castellani) Fresh preparation in liq. potassae from an old case of pityriasis flava.

Microsporon Mansoni (Castellani) Drawing taken from a fresh preparation in liq. potassæ.

it reappeared in the same place as a tiny black dot, which slowly spread. Another application of formalin caused it to disappear. From the patch a fungus was grown apparently identical with the one found in the usual form of pityriasis nigra.

Mixed Infections.—It is not at all rare to find different varieties of pityriasis versicolor in the same patient; a mixed infection of pityriasis nigra and flava, for instance, is somewhat frequently met

with. Several of my patients had on the neck a few round patches of pityriasis versicolor nigra, and on the face and chest some smooth yellow roundish patches of pityriasis flava.

DESCRIPTION OF THE FUNGI FOUND IN THE VARIOUS TROPICAL FORMS OF PITYRIASIS VERSICOLOR

Microsporon Tropicum.—I suggested this name (1905) for the fungus found in the pityriasis versicolor flava. The mycelial threads are generally thick with numerous swellings, constrictions, and other irregularities in their shape; they may occasionally contain specks of pigment. The spores are roundish or oval, 3.50 to 4.50 microns, and may have a double contour. In fresh cases the fungus is abundant with plenty of mycelium and spores which occasionally run into clusters: in old chronic patches the fungus becomes very scanty; the spores are not numerous, and generally do not collect in clusters; the mycelium is very scanty, and is even more

Microsporon Mansoni (Castellani) Preparation stained with fuchsin.

Microsporon Macfadyeni (Castellani) Parasite stained with fuchsin.

irregular in shape than in fresh patches (degeneration forms of the fungus). I have not been able to grow this fungus.

M. Macfadyeni.—This name was given by me to the fungus found in pityriasis alba. The fungus is very abundant, mycelium and spores are of small dimensions, much smaller than in the M. Tropicum and M. Mansoni. The mycelial tubes are often short

PLATE XXXV.—To Illustrate Dr. Aldo Castellani's Article, Tropical Forms of Pityriasis Versicolor.

Patient affected with Pityriasis Flava.

and thin; regular in outline and often straight. The spores are small, 3 to 3.50 microns, oval in shape, sometimes the spores form large clusters. I have been able to grow the fungus on two occasions only, using Sabourand's maltose agar. The fungus grew extremely slowly, giving rise to yellowish colonies which coalesced into a raised yellow mass, deeply pitted, very firmly and deeply rooted into the medium. Subcultures have never succeeded.

M. Mansoni.—I suggested this name (1905) for the fungus found in pityriasis nigra. The fungus is abundant: the mycelial threads are rather short, 18 to 20 microns in length, and 2.50 microns in breadth. Sometimes they may be irregular in outline, bent, banana-shaped, etc. The spores are globular and most of them very large, 5 to 7.50 microns. They are frequently arranged in clusters. This fungus is easily cultivated by inoculating scrapings of the affected patches in maltose agar, plates, and tubes. The principal cultural characters are as follows:

Maltose agar.—The growth, especially in subcultures, is comparatively rapid. After two or three days, roundish, hemispheric colonies appear: the colonies are black, sometimes with a dark greenish tint at first; the colonies may present at the periphery some radiating delicate pale greenish hyphæ. The colonies soon coalesce into a jet-black knobby mass, deeply rooted into the medium.

Common agar.—The growth is similar to that found in maltose agar, only much less abundant and less rapid.

Glucose, saccharose, mannite agar.—Same characteristics as found in maltose cultures, though the growth is less abundant.

Broth and peptone water.—The fungus grows very slowly at the bottom of the tube, forming a black, or greenish-black sediment.

Milk.—Very slight growth; the milk is not rendered acid nor clotted.

Gelatine.—The fungus grows very slowly: for the first three or four weeks there is no liquefaction of the medium, then a very slight liquefaction generally takes place.

Temperature.—The fungus grows best at a temperature varying from 30° to 32° C; over 35° and under 25° the growth is much slower.

Fructification of M. Mansoni.—The fructification has been studied by making impression preparations and hanging drops. It takes place by formation of sprouts and clusters of spores and by endoconidia: aspergillar fructifications have never been observed.

Diagnosis.—The difference in color between pityriasis flava

and pityriasis nigra is so characteristic that the two affections cannot be confused.

The diagnosis between pityriasis flava of a light variety, and pityriasis alba may sometimes be difficult; in pityriasis alba, however, there is always a fine whitish, pityriasic desquamation, the patches are slightly elevated and not so smooth; the face and chest are not the regions most frequently affected. The microscopical examination will reveal the presence of a fungus with thin, straight mycelium, and small oval spores; different from the irregularly shaped fungus found in pityriasis flava.

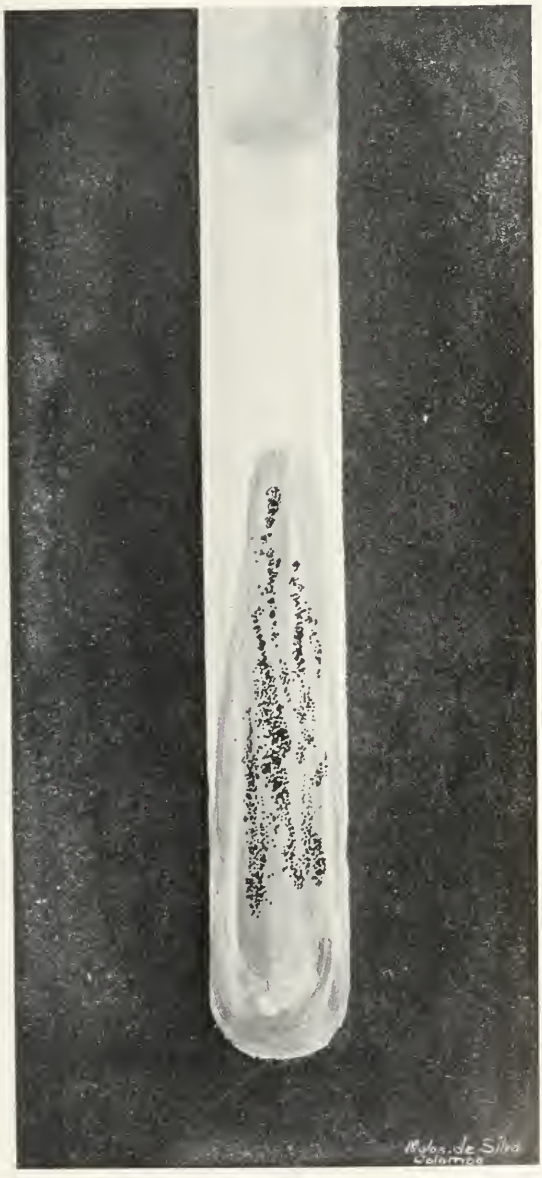
Pityriasis versicolor of Temperate Zones.—Of the various forms of pityriasis existent in the Tropics pityriasis flava *only* might be confused with the European form as regards color of the patches and the microscopical appearance of the fungus, which in neither form can be grown on artificial media.

The pityriasis of temperate zones, however, is generally not of so light a tinge, never attacks the face, and is curable with the greatest facility; while pityriasis flava affects the face more frequently than any other part of the body, and is curable only with great difficulty. It has been stated by Powell and others that the reason why pityriasis versicolor is in the Tropics so commonly found on the face is due to the fact that natives seldom wash the face. This, in my opinion, is not so; natives of Ceylon, at least, wash often and are very fond of bathing. Moreover, I have been able to make this observation: three of my attendants, Singhalese, shave regularly every other day, using plenty of strong shaving soap. I have had them under observation for nearly three years. The patches of pityriasis which were present on their cheeks three years ago are still there—in fact they have spread.

Pinta.—The various forms of pityriasis met with in the Tropics might be confused with pinta, of which, as is well known, there are several varieties, black, white, etc. The microscopical examination will clear the diagnosis at once: the fungus in all the various forms of pinta has the characters of an aspergillus; but in the various forms of pityriasis versicolor, the characters of a microsporon.

Leukoderma.—Only on very superficial observation can patches of pityriasis be mistaken for patches of leukoderma. Leukoderma patches have a characteristic dead-white color which is not found in any form of pityriasis, not even in pityriasis versicolor alba, in which there is besides, frequently, a fine whitish desquamation which is never present in leukoderma. In case of doubt the microscopical examination would establish the diagnosis at once.

PLATE XXXVI.—To Illustrate Dr. Aldo Castellani's Article, Tropical Forms of Pityriasis Versicolor.



Microsporon Mansoni (Castellani) young culture on Maltose-agar.

Circumscribed Scleroderma (Morphoea).—In this disease the patches may present a peculiar yellowish tinge, which in colored patients may resemble some varieties of pityriasis flava. In pityriasis flava, however, there is no change in the texture of the skin, which is still pliable and does not exhibit the peculiar parchment-like feeling of scleroderma. The microscopical examination will clear the diagnosis in any doubtful case.

Seborrhoea corporis.—The peculiar reddish-yellowish variety of pityriasis flava I have described might, on superficial observation, be mistaken for a form of seborrhoea corporis, very common in the Tropics among Europeans. The microscopical examination will clear the diagnosis.

Prognosis and Treatment.—None of the Tropical forms of pityriasis versicolor shows any tendency to spontaneous cure. All the forms are very chronic and may last for life. The forms that yield most readily to treatment are pityriasis nigra and pityriasis alba; the most obstinate is pityriasis flava. For pityriasis nigra and alba the usual antiparasitic lotions and ointments answer well; a salicylic spirit lotion (4 per cent.) followed by a mild mercurial ointment as, for example, white precipitate grs. x to xv to the ounce of vaseline, gives good results.

Pityriasis flava is much more difficult to deal with; turpentine applied every day and followed by a betanaphthol or epicarin ointment is often successful; but the treatment must be continued for months. It is to be noted that in several cases of pityriasis flava the fungus has apparently a deep, permanent disturbing action on the pigmentation processes of the skin, as even when the fungus has been destroyed the patches remain of a lighter color than the surrounding skin for a long time, though ultimately they become again normally pigmented.

NOTE ON TINEA IMBRICATA AND ITS TREATMENT.

By Aldo Castellani, M. D.,

Director of the Clinic for Tropical Diseases Colombo (Ceylon).

As a small addition to the present knowledge of the geographical distribution of tinea imbricata (Manson), it may be desirable to put on record the cases of the disease I have seen in Ceylon, in which country as well as in India it is stated to be non-existent.

Eleven cases have come under my observation during the four years I have been in Ceylon. The first of these cases was briefly described by me in the *Brit. Med. Journal*, Nov. 26, 1905. All the cases have come from villages near Colombo, with the exception of one—a Tamil coolie coming from Southern India—and most of them have been treated as out-patients. They were all typical cases; in all of them Manson's fungus was easily detected. I will limit myself to giving a brief clinical history of the patient whose photograph and sketch are attached in this paper.

James,—Singhalese villager, twenty-six years of age; entered the clinic on March 20, 1906. No disease of importance in the past. The present eruption, according to the patient, had begun eighteen months before in the right shoulder, and from there spread slowly but steadily; was treated without receiving any benefit by several *vederallas* (native medicine men). The disease did not cause any disturbance in the general health, but he complained of the disfigurement and the unbearable pruritus. At the time of admission the eruption was found to extend over practically the whole of the body with the exception of the scalp; the palms, soles of the feet, lower part of the face, and the axillary regions were affected, though it is generally stated that the disease does not affect either the face or the axilla, and is rarely found on the palms and soles. The eruption was most typical on the chest, back, and axilla. Several round patches were present, each presenting concentric scaly rings. The scales were flaky, very dry, of a dirty greyish color, and slightly curled; they were of various dimensions; if the scales were removed rings of concentric circular dark lines could be seen.

The number of rings forming the patch varied, in some patches eight or ten could be seen, though Tribondeau states they are generally not more than four.

On the abdomen, arms, and legs, the patches had coalesced and their disposition in rings could not be seen. The thin flaky, curled scales were, however, quite typical. On the forearms and hands numerous warts were present; the nails were thickened, having a rough surface and cracks; scrapings taken from them show the fungus. The nails being affected is against the experience of most authors.

Physical examination.—Negative for all organs.

The urine, slightly alkaline, and loaded with carbonates, this being probably due to the vegetarian diet of the patient.

Stools, ova of ascaris lumbricoides and trichocephalus dispar present.

Blood, hæmoglobin 70 (Fleishl).

Number of red blood cells	4,100,000
Leucocytes	9,000

DIFFERENTIAL COUNT:

	PER CENT.
Polymorphonuclear	50
Large mononuclear	10
Small mononuclear	20
Eosinophiles	18
Transition forms	2

A certain degree of eosinophilia was also present in four other patients. I am inclined to think that the eosinophilia is partly due to the numerous intestinal worms present in all patients.

The fungus.—Fresh preparations of scales in liquor potassae were made and also stained preparations, using Walker's modification of Morris' method. In all the cases Manson's trichophyton (T. concentricum Blanchard) was found to be very abundant. The characters of the fungus corresponded much more closely to the descriptions given by Manson, and recently by Pernet, rather than to the description given by Tribondeau and others.

Fresh preparations of scales show a diffuse mass of interlacing mycelium. The segments of the mycelium vary greatly in length. They are generally straight and of regular outline not showing swellings and constrictions. The spores are rather large, oval, or rectangular. Aspergillar fructifications which have been described by several authors have never been observed by me. In two cases

I tried to grow the fungus, using various media, but failed. My experiments, however, on the growth of the fungus were very few, and it is to be noted that Tribondeau and others have succeeded in growing it in several cases.

Treatment.—Every medical man practicing in the Tropics well knows how difficult is the treatment of tinea imbricata; it is easy to obtain temporary improvement, and even an apparent disappearance of the eruption; but as soon as the treatment is discontinued the eruption, as a rule, begins afresh.

In the Colombo clinic I have made various experiments to test

Fungus of Tinea Imbricata.
From a preparation stained by the Morris-Walker method.

the efficacy of the various medicaments by applying contemporarily different liniments, ointments, etc., to symmetrical parts of the body and comparing the results. The medicaments employed by me were sulphur, calomel, white precipitate, red precipitate, turpentine, etc.

Sulphur has practically no effect whatever on the fungus.

Turpentine induces generally a slight improvement, some scales disappearing and the skin becoming smoother; the improvement,

PLATE XXXVII.—To Illustrate Dr. Aldo Castellani's Article, Tinea Imbricata.

Patient affected with Tinea Imbricata.

however, is not permanent, and as soon as the turpentine application is discontinued, the typical scales reappear.

Calomel, white precipitate, and other ointments of mercurial preparations do not induce any improvement in the eruption.

Thymol naphthol ointments may cause a slight improvement.

Carbolic acid and epicarin ointments have no effect whatever.

Cyllin ointment (20 to 50 per cent.) may induce a temporary improvement.

Formalin is very effective for localized patches. The usual 40 per cent. solution is applied with care, treating each time a small portion of the eruption. Formalin often causes severe pain and a certain degree of inflammation, which is best relieved by applications of iced water. Soon after the application of formalin the patches become dark brownish, which color lasts for a few days, when they clear. Care must be taken not to apply the formalin to too large portions of the skin, and not to repeat the application too often, otherwise a peculiar form of depigmentation similar to leukoderma patches may appear later on, to which disfigurement colored patients strongly object.

T. iodine and linim. iodine.—T. Iodine freely applied induces a very marked improvement, which, however, is not permanent. Strong Linimenta iodi., as recommended by Manson, is most effective: it cannot be used freely, however, on patients with a delicate skin, such as women and children.

Chrysarobin.—The repeated application of chrysarobin in ointment (gr. xxx to one ounce of vaseline) may induce a strikingly rapid improvement in cases which are not of long standing; in my experience, however, the eruption recommences a few days or weeks after its apparent disappearance. Chrysarobin is a very toxic medicament, the patient must be watched and the urine regularly examined; in one of my cases symptoms of absorption appeared after a single application.

Salicylic acid and methyl salicylate have very little, if any, action of the fungus.

Resorcin and Tr. Benzoin.—Resorcin alone, or mixed with salicylic acid, in alcoholic solution and ointments, has very little efficacy. If, however, resorcin is dissolved in Tr. benzoin Co. (gr. xxx to 60 of resorcin, to one ounce of the Tr. benzoin) very good results are obtained: it is now my routine treatment for tinea imbricata.

It is to be noted that Tr. benzoin without resorcin has very

little action of the eruption. I generally apply freely the resorcin dissolved in Tr. benzoin once or twice daily on the affected regions; if the whole body is affected, one day one half is painted and the other day the other half, alternately. The treatment must be continued for several weeks.

Once or twice a week the patient is given a very hot bath and scrubbed all over with sand soap. I have treated in this way five cases, all of whom left the clinic apparently cured. I have had opportunity to see three of them again after four months: two remained well; in one, two small patches had reappeared on the right shoulder. So far I have not observed symptoms of absorption; in fact the patient who showed symptoms of absorption after chrysarobin, stood the resorcin treatment well. It is always prudent, however, to proceed at first with care, as it is well known that individuals may be met with, though rarely, showing idiosyncracy for resorcin.

Conclusions.—1. The geographical distribution of tinea imbricata is more extensive than was hitherto supposed, as it includes Ceylon and probably some parts of India.

2. The treatment of tinea imbricata is very difficult; the best results perhaps are obtained by using strong Lin. iodi. as suggested by Manson; or resorcin dissolved in Tr. benzoin Co, as suggested by myself.

TINEA INTERSECTA.

By Aldo Castellani, M. D.,

Director of the Clinic for Tropical Diseases Colombo (Ceylon).

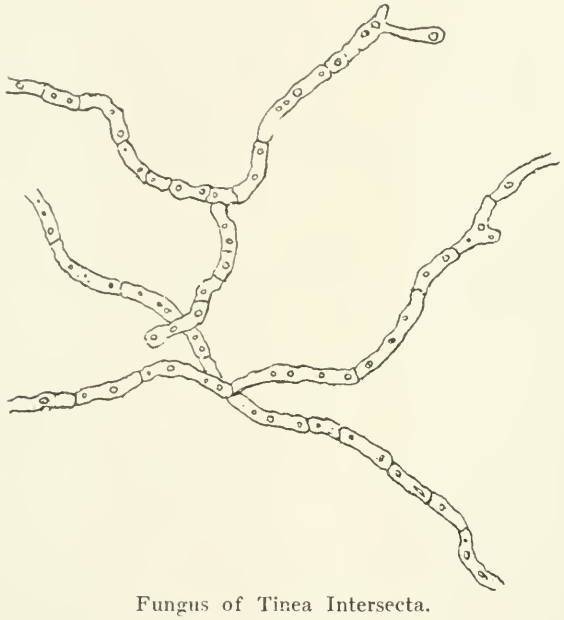
I HAVE had the opportunity to investigate, in Ceylon, two cases of a peculiar dermatomycosis, which, so far as I know, has not yet been described, and for which I suggest the name of tinea intersecta. Both patients were Tamil; in one the eruption developed while he was convalescent from typhoid fever. The eruption showed identical characters in both patients and ran the same course. Small oval or roundish, very slightly elevated, itching spots appeared on the skin of the arms, chest, and back; in the second patient on the legs also; the margins of these patches were occasionally slightly raised. The patches were dark brown, much darker than the surrounding skin, and presented a smooth tense surface at first; they increased in size slowly and some coalesced. After a certain time the surface of the patches is no longer tense; it becomes somewhat shriveled and dry; superficial cracks appear, so that white lines are visible intersecting the brown surface of the patches; later the cracks become deeper, the epidermis splits, and several flaky curled-up scales, whitish inside and dark on the outer surface, are seen; the scales are often removed by friction, etc., and whitish patches only may remain.

The eruption never develops in concentric rings like tinea imbricata; the patches remain isolated or fuse together, forming irregular larger patches. Some patches may disappear spontaneously after a time. The general health of the patients does not seem to be affected; in both my patients a slight degree of eosinophilia, 8 per cent. in one case and 6 per cent. in the other, was present. The eosinophilia, however, may have been due to the intestinal worms which both patients harbored—as shown by the examination of the stools which contained ova of ascaris lumbricoides and trichocephalus dispar.

Transmission of the disease.—I made one of the patients scratch with his nails some of his patches and then scratch a healthy Tamil coolie, who volunteered for the experiment, on the arms and upper

part of the chest. On the arms nothing developed; on the chest at the inoculated place there was—on the second and third day—much itching; on the fourth day two tiny dark very slightly elevated roundish spots appeared, these enlarged slowly and a few days later their surface showed several whitish cracks. Unfortunately at that time the coolie—who was complaining of great itching—scrubbed himself thoroughly with sand soap, with the result that the patches disappeared.

The fungus.—If a portion of one of the brown patches or a scale is removed and treated with liquor potassae, the fungus is



Fungus of Tinea Intersecta.
Drawing from a fresh preparation in liq. potassæ.

easily detected. The fungus grows apparently between the superficial and the deep strata of the epidermis. The fungus is present on the inner surface of the scales, but not on the external surface.

The fungus presents the general characters of a trichophyton; what is very remarkable is the extreme rarity of free spores, in fact in none of my preparations have I been able to detect any. The mycelium is fairly abundant, though far from being so abundant as in tinea imbricata. The mycelium is composed of long straight articulated threads which are sometimes dichotomous, the breadth

PLATE XXXVIII.—To Illustrate Dr. Aldo Castellani's Article, Tinea Intersecta.

Forearm of patient affected with Tinea Intersecta.

being between 3 and 3½ microns. Endospores are present as well as endoconidia. No aspergillar fructifications nor clusters of spores are to be seen. So far I have not succeeded in growing the fungus.

Diagnosis and treatment.—When the eruption is in the very first stage it might be mistaken for a form of tropical pityriasis versicolor. In pityriasis, however, the epidermis does not split; moreover in tinea intersecta the fungus is not found on the surface —it grows between the superficial and deep layers of the epidermis.

Tinea Imbricata.—In contrast to tinea imbricata the eruption never develops in concentric circles; is far less severe, as patches may disappear spontaneously; and is cured without much difficulty. At the time I had in my clinic the two cases of tinea intersecta, I had also two cases of tinea imbricata; the two eruptions could not possibly be confounded.

Treatment.—Tr. iodine and the usual antiseptic ointments answer well.

LARGE DOSES OF QUININE IN THE TREATMENT OF DERMATITIS EXFOLIATIVA, WITH REPORT OF SIX CASES.

W. H. Mook, M. D.,

Associate Physician, St. Louis Skin and Cancer Hospital.

THE use of quinine in the treatment of dermatitis exfoliativa, and pityriasis rubra, was begun in 1904, and was given to the first patient on the theory that he had malaria, concomitant with his skin condition, although his blood did not contain plasmodia. The first patient was an Italian, about forty years of age, suffering from an universal exfoliating dermatitis, which had been present about four months. He had been in the New York Skin and Cancer Hospital under the service of Dr. L. Duncan Bulkley, to whom I am indebted for the privilege of reporting the case, and was treated for some weeks with various local applications, and internal medication, with indifferent success. Physical examination revealed no visceral abnormalities other than an inguinal hernia. The entire cutaneous surface was covered with loosely adherent, large and small, dry scales. The skin was dark bluish red, owing partially to his normal swarthy complexion, and the only subjective symptoms were slight burning and occasional paroxysms of pruritus. There was marked œdema of the skin of his legs, with occasional excoriations and oozing. At times he seemed to be improving, when suddenly he would suffer from chilly sensations, rarely severe rigors, and the exfoliation would become more profuse, the œdema of the skin of his legs more marked, and his feelings of malaise increased. Several examinations of his blood were made for plasmodia malariæ, but always with negative results. One day, after marked chilliness, thinking malaria a complication of his skin affection, he was given ten grains of quinine sulphate and the next day he stated that he felt better than he had for some time. The dose was repeated for several days, and marked improvement in his skin and physical condition resulted. The quinine was then increased to thirty and forty grains a day, the amount being governed by the tinnitus aurium, and within ten days there was much less scaling, the œdema of his legs markedly decreased, and his physical condition wonderfully improved. The exfoliation stopped within four weeks, and the patient was entirely well within two months. He was then operated upon

PLATE XXXIX.—To Illustrate Dr. W. H. Mook's Article.

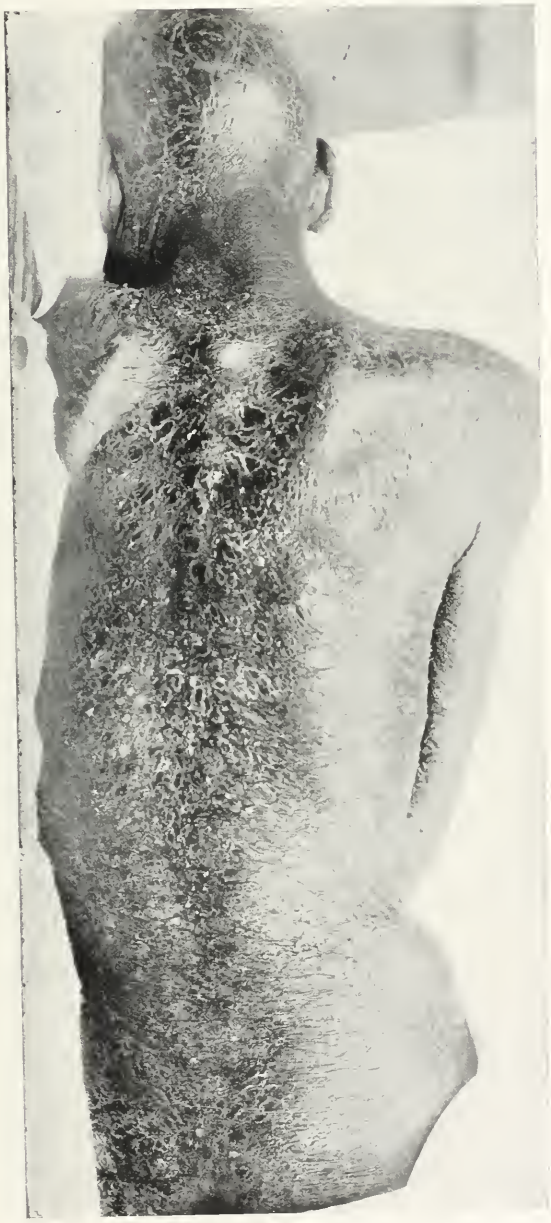


Fig. 1. Pityriasis Rubra (Hebra). Fourth patient.

for his inguinal hernia, from which he made an uneventful recovery; the wound healed by first intention, and he was discharged cured.

The second case, L. K., twenty-five years of age, a patient at the St. Louis Skin and Cancer Hospital, service of Dr. M. F. Engman, was seen two weeks after the attack began. His first symptoms were a feeling of prostration and malaise, having been perfectly well until the attack, and within twenty-four hours his face and trunk became very red, and he suffered a burning sensation all over his body. His hands and face, especially the eyelids, became puffed with œdema, and he suffered from chilly sensations. The erythema spread rapidly and became universal. There was marked enlargement of the inguinal glands. A tentative diagnosis of ptomaine poisoning, with toxic erythema, was made, and he was treated accordingly. Within ten days exfoliation was profuse, with no diminution in the erythema, and no improvement in his physical condition. The case then looked more of the dermatitis exfoliativa type, and he was given ten grains of quinine sulphate three times a day, with a local application of Lassar's paste. Within a month the scaling had stopped entirely, though the skin was still somewhat erythematous. The quinine was continued, and within three months he was discharged entirely well. He remained this way for two months, when he returned to the clinic suffering from an erythema of the face, head, and hands. He again entered the hospital and was given ten grains of quinine three times a day. For a few days he suffered chilly sensations, but the erythema did not spread, and the exfoliation which had begun, rapidly subsided. He was discharged three weeks later entirely well.

The third patient, J. L. G., was a case of undoubted pityriasis rubra of the Hebra type. He was a private patient, referred to Dr. M. F. Engman, to whom I am indebted for the privilege of reporting the case. He is a native of St. Louis, seventy-four years of age, and had been suffering from his skin affection eighteen months when first seen. He stated he had suffered frequent attacks of rheumatism during his life, until an operation for cataract in his left eye was performed, after which the eye had become destroyed, possibly from infection. He suffered no more from rheumatism. About this time his skin began to get red and scaly on his face and scalp, and the condition spread rapidly over his entire body, becoming an universal exfoliating dermatitis. He was first seen on July 25, 1907. Physical examination revealed no visceral lesions other than cataract of the eye, though he complained of general weakness. His pulse was full and regular, his temperature normal, and appetite and di-

gestion good. Examination showed his entire cutaneous surface to be covered with masses of large and small scales, very profuse and loosely adherent. The hair had disappeared except in small areas on the posterior scalp, and what little was left was fine and dry. The skin was of a violaceous hue, especially on the trunk and lower extremities, and a livid red on the face and neck. In texture, it was considerably thickened, and could be grasped between the fingers with difficulty. The nails, especially those on the toes, were corrugated, thickened, very rough, and yellowish in color. The legs were almost twice their normal size, from the œdema, and the lower halves were covered with excoriations from which there was considerable lymph constantly oozing. He was subject to frequent chilly sensations at irregular intervals, with occasional severe rigors. He stated he seldom, if ever, suffered febrile symptoms. The blood examination, made by Dr. W. Baumgarten, was as follows:

Red blood corpuscles	5,016,000
Hæmoglobin	65%
Color index	.648
Leucocytes	2.6
Differential count	332 cells counted
Small mononuclears	16.8
Large mononuclears	none
Transitional	none
Polymorph. neutrophiles	60.2
Eosinophiles	21.6
Mast Cells	1.2
Myelocytes	none

No malarial parasites found, and red cells very pale. No misshapen, or nucleated cells.

Five grain quinine capsules were ordered every two hours, oftener if possible, until tinnitus aurium would be produced; starch and soda baths, and a very mild tar oil.

Three days later he was visited again and the scaling and œdema of the legs were considerably reduced. He had been taking fifty grains of quinine daily. The specific gravity of his urine was 1011 and there was a great excess of indican, otherwise normal.

August 4th, ten days later, nearly all of the œdema had disappeared from his legs, the excoriations had practically healed, the exfoliation of the epidermis greatly lessened, and his physical condi-

PLATE XL.—To Illustrate Dr. W. H. Mook's Article.

Fig. 2. Pityriasis Rubra (Hebra). Fourth patient.

tion had improved wonderfully. His afternoon temperature on some days went down to ninety-seven degrees, though it was usually normal. All local applications, except a daily starch and soda bath, were stopped. The quinine was ordered to be increased, giving ten grains every two hours unless contraindications should arise. He was again seen the next week, and had made rapid progress. There was very little scaling, the skin was much paler, the œdema of his legs had entirely disappeared; he slept ten or twelve hours every night, his appetite increased, and he stated that he was feeling very comfortable. His quinine had been increased until at one time he had taken eighty-five grains over a period of twelve hours, producing marked tinnitus aurium, and rather marked deafness: it was then reduced to seventy grains daily, from which he suffered no inconvenience, other than slight deafness. His urine showed no abnormalities at this time. From week to week the quinine was reduced to ten and fifteen grains daily; but this procedure was followed by a reappearance of the scaling and œdema of the legs, with oozing, which rapidly subsided under increased doses of the quinine. At no time did his urine show albumin, or sugar, and was usually light amber in color. He seemed to suffer no inconvenience from the quinine, except slight deafness, when the daily dose was too large. He remained in this condition for two months, and finally left the city for a visit to Michigan two months ago, at which time there were only a few slightly scaling areas.

In answer to a request from his daughter regarding his condition, I will quote a portion of her letter.

"The quinine was stopped entirely for a few days prior to his departure. His condition was worse about the last days of this month (January), and I was very much worried about him as he seemed so much worse. Moisture exuded and his clothing adhered to the skin of his legs so that it was difficult to remove. For several days he refused to take the quinine as he imagined it was hurting him. He was so nervous, cross, and irritable that I did not know what to do. Finally I persuaded him to go back to the quinine, with the result that the skin dried, the swelling subsided, he was quiet, and rested during the night. Yesterday and to-day he has been comparatively easy. There is still some little scaling."

The fourth patient was a negro woman, another case of pityriasis rubra of the Hebra type, and so far as I know, the only case of this disease occurring in the negro. S. C., age about thirty-five years, entered the St. Louis Skin and Cancer Hospital, July 3, 1907,

under the service of Dr. M. F. Engman. Only a clinical history of this patient will be given, as a detailed report in full of the study of the case, with the post-mortem findings will be published later. She was very much emaciated, weighing about eighty pounds, and was very weak. Her health had been very good up to the time of the present illness, which had begun twenty-one months previously. In September, 1905, her hands became swollen and scaly, and she suffered with a severe chill, followed by fever lasting several days. The palms were fissured, and soon the feet were involved in the same manner. A scaly condition developed and gradually spread up the legs and arms, over the body; the face and head becoming last involved. After the entire cutaneous surface had become involved in a continually scaling condition, the hair began to fall, until there were only a few left on the occipital region. Even the eyelashes had disappeared. The scales, loosely adherent, were large and small, dry and gray in color. The skin was very dry, perspiration occasionally appeared, but only on the face. The only subjective symptoms were occasional pruritus, burning and pain from ulceration. She stated that during the earlier part of her illness her legs were much swollen. When she entered the hospital the skin of the legs, ankles, and feet was atrophic, and many reddish-white cicatrices were seen. The entire hands were very atrophic, the scars having become so marked as not to allow more than slight bending of the fingers. The entire skin of the chest was cicatrized, and many ulcerations, secondary to the atrophy, were present. The legs too, showed isolated superficial ulceration. Examination of the urine showed 1008 Sp. Gr., no albumin or sugar, no indican, few epithelial cells, and leukocytes, urates and uric acid.

Several examinations of the blood, made by Dr. G. McConnell, the Pathologist of the hospital, showed she had acute lymphatic leucæmia. An average differential count being as follows:

Erythroctes	2,200,000
Leucocytes	480,000
Polymorphonuclear	15%
Large lymphocytes	16%
Small lymphocytes	67.4%
Transitional	.8%

No eosinophiles found.

Two weeks after her entrance into the hospital she was given quinine sulphate, thirty to forty-five grains a day, according to the

PLATE XLI.—To Illustrate Dr. W. H. Mook's Article.

Fig. 3. Dermatitis Exfoliativa. Sixth patient.

tinnitus aurium produced. The skin began to improve almost immediately; the scaling, after some weeks, being hardly noticeable; the ulcerations healed entirely, and she slept much better. The chilly sensations ceased entirely while she was taking the quinine. Her physical improvement too, was quite marked for two months. The skin began to scale somewhat when the quinine was discontinued, but only in small areas, and hardly noticeable compared to her condition when she entered the hospital. Then she began to get weaker, all medicine produced nausea, and ulcerations reappeared, and she died a month later.

The fifth patient was a patient of Dr. M. F. Engman's, to whom I am indebted for the privilege of reporting. F. L., aged fifty-four, was suffering from an erythematous, scaling condition of his entire body. The eruption began in the latter part of September on the inner surfaces of the thighs, as itchy papules. Within a week the entire surface of the body became red, and covered with fine scales, becoming an exfoliating dermatitis. For some weeks before the eruption appeared, the patient suffered from chills and fever, followed by sweats and pains in the bones. Examination of the blood showed the presence of malarial parasites, and he was given calomel and quinine, and a one per cent. ichthyol ointment for local application. The eruption almost entirely disappeared in ten days, the skin was normal in color, except on hands where it was bluish red. He was given capsules containing arsenic, quinine, and strychnine, and did not return. He was seen several times later, and reported that he suffered no relapse of his skin affection.

The sixth patient, J. B., entered the St. Louis Skin and Cancer Hospital August 13, 1907, service of Dr. J. B. Keber, suffering from an universal exfoliating dermatitis. He was a laborer, forty years of age, and the present skin condition had been present one month. He had suffered numerous attacks of psoriasis. He was in good physical condition, no visceral lesions being found. The entire skin surface was livid red in color, and covered with greasy yellowish, large and small scales. The exfoliation was very profuse, and he suffered from occasional chilly sensations. The dense collection of greasy, yellowish scales on the scalp suggested seborrhœic eczema, and he was treated with sulphur-salicylic acid, and tar ointments for two weeks, with no improvement in the condition. Frequent urinalysis showed absence of albumin, sugar, and indican, and an average sp. gr. 1012.

Examination of blood, by Dr. G. McConnell showed,

Hæmoglobin	85%
Erythrocytes	4,704,000
Leucocytes	20,000
Polymorphonuclear leucocytes	69.6%
Large lymphocytes	11.6%
Small lymphocytes	15.6%
Transitional	3.2%

No eosinophiles found.

He was given quinine sulphate, forty-five to fifty grains daily, and a daily starch and soda bath. Within a few days the scaling became much lessened, and the erythema much paler. Two weeks later the eruption had broken up into discrete, sharply defined, erythematous patches, slightly elevated, and now covered with silvery scales, with large areas of perfectly normal skin intervening. Within another week the eruption had developed into a typical psoriasis, which showed no further improvement under the continued large doses of quinine, and it was stopped. Ungt. Dreuw was then applied, and the lesions improved very rapidly for two weeks, when a mild chrysarobin dermatitis began to develop, and the ointment was discontinued. His skin became universally red again, with some scaling, but rapidly broke up into the psoriasis patches, under the soothing ointment, much less pronounced than formerly. Patient refused further treatment, and was lost from observation, suffering when he left from a rather typical psoriasis.

In reporting the series of cases treated with quinine empirically, not even based on a scientific theory, nor a satisfactory explanation of the results, the bare facts of the clinical observations are given.* In looking over the literature on the subject, I was gratified to find that J. F. Payne, in an article "On Persistent Erythema and its Treatment," *Brit. Jour. Derm.*, May, 1894, reports a series of cases of several varieties of erythema, in which he used quinine sulphate with rather remarkable results. He concluded from his observations on erythema that quinine was useless unless given in large doses, and offers no reason for its use.

In all of the cases embodied in this report the drug was given in large doses, and the tolerance in all of them was very striking. The urine was examined weekly, and no untoward indications, such as hæmaturia or albuminuria were observed, even when the dose ran as high as, in the third case (pityriasis rubra), eighty to eighty-five grains was given during a period of twelve hours. In these

cases no attention was paid to slight deafness, and the dose was only reduced when the tinnitus aurium was quite pronounced.

The effect in all was noticed in a few days, and it would be difficult indeed, to explain such rapid subsidence of exfoliation of the skin, the reduction of erythema, and œdema, when present. The slight relapse of the skin condition in the third patient when the dose was reduced from sixty to twenty grains a day, and the rapid improvement following an increase in the dose, was significant of the fact that results could only be obtained with large doses.

* Cushney in his chapter on quinine states:

"Perhaps the lessened formation of uric acid, and other poisonous products, may be suggested as a possible cause of the improvement when given in neuralgia and headaches.

Alteration in tissue change occurs throughout the mammalia, and consists in a marked diminution in the destruction of the nitrogenous constituents of the tissues. After administering quinine the nitrogen is at first augmented for a few hours, and then dimnished to a considerable extent, due to a restricted production of all the nitrogenous constituents of the urine, but especially of the urea and uric acid.

Phosphates and sulphates undergo a corresponding alteration, but all metabolic changes are not affected, for the carbonic acid exhaled, and the oxygen absorbed present no alteration in amount, so that the oxidation of the tissues cannot be said to be altered, but only the breaking down of the nitrogenous bodies.

Nitrogenous food is not dissipated so rapidly, but is stored up in some unknown form under quinine."—*Textbook of Pharmacology and Therapeutics.* Arthur R. Cushney, 1906.

SOCIETY TRANSACTIONS.

THE NEW YORK DERMATOLOGICAL SOCIETY.

Regular Meeting, April 28, 1908.

Dr. Morrow, in the Chair.

Case of Psoriasis of the Palms. Presented by Dr. Dade.

This patient for the past two years or more has had these lesions on the palms, and no lesions elsewhere on the body until within the last two months, when a spot appeared on both elbows. These elbow and palmar lesions are the only manifestations of the diseases to be discovered, and the case may be said to be, or, at least, have been up to the time the elbow lesions appeared, one of the rare instances of psoriasis occurring on the palms alone.

Dr. Fordyce said that two years ago he had presented a case of psoriasis of the palms where the lesions were more diffuse and also appeared on the backs of the hands. The attack cleared up under tar treatment, but later recurred. The diagnosis was confirmed by the subsequent development of lesions on other parts of the body.

A Case of Scleroderma. Presented by Dr. Jackson.

The patient is a girl 3 years old. There is a history of two miscarriages by the mother before the birth of this child, and of two afterwards. There is nothing special in the history of the child excepting an obstinate diarrhœa last summer. The disease began suddenly in June, 1907, and is said to have undergone no change since then. It takes the form of a characteristic band about two inches wide that runs from a little below the groin down to the heel on the inner side of the right leg. The band is broken for a space just below the knee.

The diagnosis was accepted without dissent.

Dr. Fordyce agreed with the diagnosis, but said that he had never before seen a case in so young a child.

Case of Lupus Erythematosus of Mucous Membrane of Lip. Presented by Dr. Dade.

The patient is the one presented to the Society several times already, having been treated eight years ago with liquid air. There has been, as you see, no return of the disease on the face where treated, and he now comes back for the lip lesion which has developed, he says, within the last four months. I shall apply liquid air to the lip and hope to get as good a result as the face shows, then present him to you again next month for inspection.

Case of Lupus Erythematosus. Presented by Dr. Whitehouse.

This case was of about three years' duration. The disease began underneath the eye on the right side of the face, in a man of about 30 years; another patch lower down developed almost simultaneously. Other lesions appeared through the scalp, and a year ago one developed on the lower lip near the left angle of the mouth. There is a general swelling of the lip, scaliness, and redness, in addition to which there is a circinate patch on the mucous surface of the lip near the left corner of mouth. The scarring is rather deep for lupus erythematosus. He intended to treat the case with liquid air, or perhaps liquid carbonic in the form of carbon dioxide snow.

Dr. Sherwell agreed with the diagnosis, and spoke of a case to which he had referred on a previous occasion, in which the lupus had destroyed more than on the surface (Cazenave and Biett), had attacked around the oral cavity and nose, and then went through the mouth, causing lesion of the same character all over pharynx and affecting the tonsils and going down into the larynx, and taking off a crescentic piece of the epiglottis. He followed the lesion with his glass as far as he could see it, down the trachea to the major bronchi, without the manifestation ever becoming lessened. The case was presented before the Laryngological Section of the Academy. It was a marvelous case in its way on account of its persistency and the equableness of its course. Nothing could stop it. At first it was thought to be tubercular lupus on account of the destruction of tissue, though the characteristic apple-jelly nodules were not much, if at all, in evidence. The case seemed to be of a mixed type, encroaching upon lupus vulgaris. The patient was a hearty girl and afterwards developed into a hearty plump woman. This case occurred twenty years ago, and was mentioned now as an instance of how the lesion sometimes extends through the mucous membrane as well as the cutis, and yet no evidences of general tuberculosis were ever discovered.

Case of Lupus Erythematosus of the Nodular Type. Presented by Dr. Fordyce.

M. McC., 24 years old, married five years; no children. Her mother died at the age of 54 of cancer; she did not remember her father. Her husband has had a cough since she married him; he is thin and drinks heavily. She thought he had tuberculosis; his mother died of that disease.

In the summer of 1907 numerous pea-sized to smaller lesions appeared over the upper portion of the chest, back, neck and arms, many of which disappeared spontaneously after six months. About the same time she developed purplish-red nodular lesions over the bridge of the nose, cheeks, forehead, back of the ears, neck, &c. At the present time she was in fairly good general health, but she coughed a good deal last winter. Her menstruation was slight; she has never been pregnant. A few dry rales could be heard over the upper portion of her chest. She complained of weak spells but never faints. Lately many new spots have appeared over the forehead and other portions of the face. These lesions were purplish-red, many did not scale at all and showed a marked infiltra-

tion. When they reached the size of a pea, the central depression could be made out. She had had the Calmette ophthalmic test on three different occasions without the slightest reaction.

The diagnosis was accepted without dissent. Dr. Jackson said that these nodules seen by themselves without other lesions would be very difficult to diagnose.

Dr. Whitehouse said that, aside from the nodular characteristics, the case was very like the first case which he had treated with iodoform, some 9 years ago, and which had recovered. His case had lesions on the forearms and chest similar to these, those on the chest having been brought out by the application of a capsicum plaster; they persisted for a year or two, but were superficial. The patient was treated by lotio alba for a long time, and then, after taking the iodoform, for a period they grew very much worse, later subsiding and dying away. The superficial type of lupus erythematosus responds to iodoform—given, one grain three times a day in pills. The stomach stands the remedy very well, and patients can take it for weeks at a time without ill effect.

Case of Urticaria Pigmentosa. Presented by Dr. Jackson.

The patient is a girl about 22 months old. The disease is said to have begun about two months ago, when she was about 20 months old. At first, the mother stated, the lesions were like "hives," and itched. These did not disappear, but left behind yellowish, buff colored, or yellowish brown elevated, large pea-sized lesions. When these are rubbed some of them can be made to swell up and become red. The lesions are scattered sparsely over the trunk and limbs. The skin is not scratched, so it is not itchy at present. The child lives in a basement. Its general health seems to be fairly good. An elder sister is said to have had a similar eruption. When she was examined light brown stains were found, but no elevated lesions.

Dr. Sherwell said that it might almost be the same baby as that of the illustration in Hyde's book, the similarity was so close.

Dr. Trimble said that Dr. Fox had requested him to state that the case of the 13-year-old girl presented by him at the previous meeting of the Society had had a very careful examination and no evidence or history of scabies could be found. The pigmented lesions were more numerous and much more marked than in Dr. Jackson's case, presented to-night, but friction would not raise a wheal in any of the old lesions, and from the mother's statement the disease had lasted only one year.

Dr. Jackson said that the condition was indeed a very rare one, and this was the first case he had seen at the College Clinic in twenty-seven years.

The child had a chronic diarrhœa last summer.

Dr. Morrow said there was no reason to question the diagnosis. The condition began when the child was 20 months old, without assignable cause. Many of the cases reported in the literature of the subject began after vaccination or some infantile disease. He has seen a number of cases characterized by factitious urticaria. He had endeavored to determine its presence or absence in this case, but the child was removed before it was time for the wheals to appear.

A Case of Malingering. Presented by Dr. Jackson.

Miss G., æt. 22. Manicurist. The young woman seems to be in good health. Examination of her urine fails to show anything abnormal.

She states that the disease she now presents began about Christmas, 1907, as a scaling of her eyelids, and swelling of her face. These attacks of swelling and redness, with itching and some moisture have come on ever since at weekly intervals, and always at the end of the week. A well known dermatologist has treated her for some three months, but without success. She came to me April 6th, when she showed a little redness of the face, the skin not being much altered in appearance or feel. One week afterward there was a little swelling about the eyes. On Saturday, the 25th, she came again with more pronounced swelling of the face, and redness that ended abruptly at the hair line, and in a straight line just under the chin. I asked her what she used to make her face red. She showed no indignation at the question, but denied that she had done anything.

Dr. Klotz, without doubting the correctness of Dr. Jackson's diagnosis in this case, insisted that there exists a periodical erysipelas of a mild type, which repeats itself very frequently. He himself had suffered from something of this character for two winters when he was at college. It was restricted to the nose and cheeks. For a time it used to appear every other Sunday, especially if he wanted to go out. It was never accompanied by any general symptoms, and he felt perfectly well except for the general swelling of the face.

Dr. Jackson said that he was convinced that the girl was malingering. She had been under the care of a very good dermatologist in this city, and had deceived him for months. She is a manicurist; lives with a sympathizing aunt, and probably gets up a dermatitis on Saturday night so that she will not have to go to work Monday morning. He had written her the night before, and told her that he hoped that her face would look bad this evening when she came before the society, and it did. He had asked her what she did to secure the effect, and she said 'nothing at all," but did not seem angry at the question. She evidently had enjoyed herself very much in being the object of attention. She has talked about eczema, and wanted to know if there is not a discharge about her ear. The peculiarity about the case is the sharp edge of the inflammation along the hair line, and just below the line of the lower jaw.

Case of Tuberculide. Presented at the last meeting by Dr. Fordyce.

Dr. Fordyce said it was a question at the last meeting whether the patient had syphilis or not. The Calmette ophthalmic reaction which was present in a marked degree when the patient was shown at that time had passed off under the use of cold compresses and installations of a ten per cent. solution of argyrol. The suppurating lymph nodes were still present in the neck, but were resolving slowly under applications of ichthyol and packing the sinuses with balsam of Peru. He now had an outbreak of fresh lesions which were pustular and very superficially situated. The

pus soon dried into crusts which were firmly adherent and when separated left a depressed scar. In addition to scattered lesions he had groups of papulo-pustules. The deeper scars which he had over the body, patient stated resulted from lesions which were exactly like those which he at present presented.

Dr. Bulkley said that he could see nothing at all of a syphilitic nature. All of the scars might be made by a tuberculide.

Dr. Klotz said that in December, 1907, the patient had different lesions, which disappeared under specific treatment by injections. The scars on the tattooed parts of the arms differed from the deep-seated ones on the back and face. The new lesions now present are like those which continued to appear under the syphilitic treatment. The case was originally suspected to be small-pox, and was several times inspected by the Board of Health.

Dr. Fordyce said that a careful search had been made for evidence of syphilis and a history of that infection, but neither could be found. He was more convinced than ever that the scars and lesions on the patient's body were a tuberculide and not syphilis.

Xeroderma Pigmentosum. Presented by Dr. Fox.

The patient is 27 years of age, of Irish parentage. For the past two years he has worked in the Brooklyn Navy Yard. There has been no disease like the present one in any member of his family. As a boy his face and hands were covered with freckles. These disappeared from his face when he was about 17 and have not reappeared since then in this region. Two years ago he first noticed the lesion in the middle of his left cheek which is now ulcerating. The red patches on the face have existed for a number of years, and the scaly lesions of the face for the past year. The patient presents on the face telangiectases and atrophic spots. The general health is good. The eruption is similar to that of a patient from the Skin and Cancer Hospital shown on March 27, 1906.

Dr. Fordyce saw little to justify the diagnosis of xeroderma pigmentosum. He looked upon the case as one of precancerous keratosis developing on a seborrhoic dermatitis with secondary epithelioma.

Dr. Johnston stated his belief that the disease was a form of xeroderma pigmentosum.

The man was a seaman, exposed to the elements, and the condition might be attributed to his occupation. It is probably allied to sailor's skin.

Dr. Sherwell said that he believed it to be as Dr. Fox had suggested, a case of xeroderma pigmentosum; also said that as they always had as sequel an epitheliomatous condition, it was analogous from that point of view to the so-called premycotic stage of mycosis fungoides, and hence might be called the first stage of epitheliomatous condition.

He was also much struck by the resemblance of this telangiectasic state to that often produced after the healing of an X-ray burn. He had seen several of this nature; one had been particularly striking. It was of a gentleman distinguished in a scientific way, who for some affection of the kidneys or bladder had been radiographed to ascertain as to whether or no a calculus was present. No apparent long exposure was made, but he developed a bad burn over the abdomen which took a long time to heal, and at points over these

telangiectases and evident areas of epitheliomatous degeneration occurred, which were cured by operative procedure, so far, a lapse of about eighteen months, without recurrence.

Dr. Johnston said that the patient has three precancerous lesions on the back of the hand.

Case for Diagnosis. (Presented previously.) By Dr. Fox.

Dr. Fox said that he had presented this case a month or two since. The man was a Roumanian and had been in this country only a few months. When shown before he had some sharply defined patches on the abdomen, back, and thighs, running up in bands beneath the scrotum, but differing from eczema marginatum in being circumscribed instead of diffused as one might expect from the location. It was the general idea of the members then that the condition was that of tropical ringworm. A pathological examination had been made from a section removed from the back, and no parasite was found in the scales. Treatment with green soap had removed the intense itching of which the patient complained, leaving a simple pigmentation of the skin. The infiltration is lessened, although the skin is still somewhat thickened. The pigmentation is more marked than it was a month ago. There is considerable dermatitis in the vicinity. The patch on the abdomen is not as circumscribed as it was. There is a diffused condition where the sharply defined bands were at the time of the last meeting. The pathological report was that it was a small-celled inflammation, apparently what would be found in a chronic eczema, which was the diagnosis first made. It itched severely at first.

Bromide Eruption. Presented by Dr. Fordyce.

The patient was a tailor, 26 years old, born in Russia. He was an epileptic and had been taking bromides for two years. He suffered from a fungating eruption of the lower extremity for eight months. It bore a striking resemblance to a serpigenous syphilide, as it presented central resolution with active lesions at the margin. These marginal lesions were elevated, fungating, quite painful and the seat of numerous miliary abscesses. Dr. Fordyce had observed lesions of this type on the lower extremities in a number of individuals who had taken bromides.

Multiple Fibroma. Presented by Dr. Trimble.

The patient, a young man, aged 20, had a number of deep-seated small pea-sized tumors resembling lymphatic glands in a chain all over the upper part of his body, and a number of pigmented patches on his back. The patient noticed the first tumor in the right axilla 5 years ago. It was not a soft fibroma, but looks very much like what Von Recklinghausen described. There are two very large pigmented patches on his buttocks, and there were atrophic spots also. He had frequently seen the soft fibroma type, but this was the first time he had seen this variety.

Dr. Fordyce said the case belonged to the group of cases designated as von Recklinghausen's disease. We had present here not only the tumors, but the café-au-lait pigment areas in the skin and atrophic lesions over the pectoral muscles, where tumors had evdently disappeared and produced these atrophic spots in the skin. The case presented by Dr. Trimble, however, differed from the ordinary one of molluscum fibrosum in that the growths were of the hard variety instead of the soft. Dr. Fordyce had observed that when the tumors were deeper-seated they were usually firmer in consistence than when projecting from the surface.

Dr. Dade thought it a typical case of Von Recklenhausen's disease.

Case of Subcutaneous Abscesses from the Intramuscular Injections of Mercury. Presented by Dr. Dade.

Scattered over both buttocks are eight or ten cicatrices the size of a quarter of a dollar, pigmented and punched out with considerable induration beneath in the tissues. The patient presented himself to-day at the clinic, asking for some treatment that would not be so painful. He refused to return when he had received the injections on account of the pain they caused and subsequent ulcers. He is shown only as an evidence of what may occur in this method of treatment for syphilis.

Dr. Winfield said that the hardness of the tumors and their deep seat formed a very interesting case.

Dr. Bulkley said that years ago when the use of hypodermic injections of morphine was new, a patient had been sent to him with hundreds of self-inflicted scars and indurations caused by the treatment. He had never seen anything of the kind, however, in connection with mercury injections.

Dr. Klotz said he thought it was due to injections of bichloride of mercury. He had seen such lesions repeatedly when the injections were made in the cutis itself—not makng the injection deep enough. Such lesions are very slow in healing.

Dr. Fordyce told of a case with hundreds of superficial scars, accompanied by a bluish discoloration. This patient, a woman, had used cocaine.

Dr. Whitehouse said that he had seen two cases of the type mentioned by Dr. Fordyce—one, a woman on the Island, in the Manhattan State Hospital for the Insane. The other had been presented before the Manhattan Dermatological Society. It was thought then that it was due to some chemical reaction between hydrochlorate of cocaine and the metallic needle. It was a permanent bluish tattoo, almost like the tattoo with india ink. Patients using only morphine escaped this trouble, but in both of these cases either cocaine alone was used or both cocaine and morphine.

Dr. Morrow said that many years ago, when this treatment was in its infancy and the technique was not so well understood as now, such conditions were very common. In 1887, when he was in Paris,—the first year insoluble preparations were generally introduced—the hypodermic injections were not made deep into the intramuscular tissue, and there were many cases of abscess and cicatricial scars very much like this. In a number of cases that had died from some intercurrent trouble, there were numerous nodules which were caused by the calomel. These were excised post-mortem, and were perfectly black, some the size of a filbert, and some the size of a walnut. There seemed to be a complete necrosis of tissue, but it was not broken down nor suppurating. He had seen no such condition for many years.

Case of Papillomatous Syphilide. Presented by Dr. Schwartz.

The lesion was of two years' duration. The man had gonorrhœa a year ago, but there was no history of a previous rash on the body. It started on the right inner canthus of the eye and spread to the extent now seen, in a period of two years.

Dr. Fordyce thought the case was a late syphilide, but would not rule out lupus absolutely. It had only existed for two years, but some cases of lupus have a rapid course and he would not eliminate this diagnosis without first subjecting the patient to the therapeutic test. He would very much like to see the case again after a month's treatment.

Drs. Klotz and Bulkley agreed with the diagnosis of syphilis.

Leprosy. Presented by Dr. Bulkley.

Dr. Bulkley presented a patient with leprosy exhibiting unusual characters. The manifestations of the disease were almost wholly confined to the lower extremities and forearms, and when shown at a former meeting the case had been regarded as one of mutiple pigmenting sarcoma. Most of the lesions were small, less than an inch in diameter, generally oval, and slightly raised above the surface. They had, however, a soft pulpy feeling and were of a coppery brown color, other than that seen as pigmenting sarcoma. There was nothing about the face, nose or ears to suggest the diagnosis of leprosy. The history was as follows:

Ernest G.; Russian; age 26. Occupation, sailor. Family history, negative. Personal history, negative (pleurisy six years ago, erysipelas five months ago). First noticed small papules on legs two and a half years ago; six months later they appeared upon the thighs, and one year after first appearance patient noticed a few pin-head papules upon the arms and forearms. In the meantime some of the papules had increased in size, the majority having assumed their present appearance four months ago. His occupation has taken him to Norway and English ports. Has never been in the tropics.

Pathological Report. "Forearm." A small round nodular piece of tissue. Micro-sections show large masses of lymphoid and epitheloid cells with many large giant-cells; staining for bacteria shows the large giant-cells and many epitheloid cells to be crowded with leprosy bacilli. Diagnosis, leprosy.

Dr. Jackson said that it was a most interesting case. He had never before seen one of just this type, most of the cases coming to New York being of the anæsthetic macular or mixed types.

Dr. Dade said that he had presented the case in January last for diagnosis, but at that time the patient had no lesions on the face whatever; they were confined solely to the extremities. The diagnosis of sarcomatosis then made was influenced by the microscopical findings.

Dr. Whitehouse said that when he saw the case before it had the clinical features of sarcomatosis. He did not recall that there were any lesions on the face or trunk.

Dr. Winfield said that he had seen the case presented at another Dermatological Society before Dr. Kingsbury had made the microscopical report. A number of the men then thought it was sarcomatous. The patient then had not so many lesions on the body as he has to-night.

Dr. Johnston said that the patient was first seen in Bellevue, and he then had no lesions on the body or face, but he had failed then to examine the nerve trunks, or he would not have been deceived. The histological specimens, unstained for bacilli, suggested lepra as little as the clinical picture. The lesion was mistaken for sarcomatosis.

Dr. Foudyce said that the case had been brought to his office by Dr. Kingsbury, and he had no hesitation in making a diagnosis of leprosy from the clinical appearances of the lesion. In order to make the diagnosis absolutely certain, however, he had made a biopsy and demonstrated the presence of the lepra bacilli.

Dr. Morrow said that while he did not know what the objective appearance was when the case was presented before, he would not have the slightest hesitancy in making a diagnosis of leprosy at the first glance from the present appearance of the lesions. The nodules very often come out in more or less symmetrical groups, and they sometimes spontaneously disappear. He had seen a case where there were 200 or 300 nodules—a recent development—and under the influence of a change of climate, etc., and very simple treatment, the skin cleared up, but twelve months after there was another development, and the patient's condition was much worse than before. When in Molokai he had examined several hundred lepers, and in as many cases the lesions were practically confined to the lower limbs and the characteristic development about the brow and ears were entirely lacking. It is usual, where there is such a marked development of lesions on the lower limbs, to see them on the facial mask; but from the color, texture, and consistency of the lesions he would not hesitate for a moment in the diagnosis. There was no need to wait for a microscopic examination.

Cornu Cutaneum on the Glans Penis. Presented by Dr. Klotz.

Patient a man; 38 years of age. He had been under the doctor's treatment in 1893 for a very obstinate scaling condition of the glans which had previously existed for about 8 years, having appeared soon after an operation for phimosis, without any venereal infection. The affection healed after about 5 months during which various remedies had been applied.

During the years 1895 to 1897 the patient was under treatment for a very obstinately returning chronic gonorrhœa and urethritis. In April of 1896 the scaliness of the glans again became aggravated, but disappeared within a few weeks after treatment with an ointment of the white precipitate of mercury and oil of cade. During the following fall and winter the scaling returned again, but finally healed under applications of tumenol.

I did not see the patient professionally until April 5, 1908, when he exhibited a cornu cutaneum on the dorsal aspect of the glans penis; its formation had begun about one year previously. After growing for some time it had fallen off spontaneously; the present growth began about 8 months ago. The hope of the patient that it would come off again spon-

taneously had not been fulfilled, so he came to be relieved of it. The entire glans was somewhat swollen, and extremely sensitive to the touch; it was partly covered with thin, loosely adherent scales, except on the left side where the point of the horn had pressed against the surface and had caused an abrasion. As the patient was not willing to stop his work, an immediate removal of the growth was out of the question. I advised applications of a 1 per cent. solution of caustic potash around the base of the horn, besides an 2 per cent. resorcin ointment on the irritated surfaces.

When the patient came back on April 11th, the horn could be removed by moderate traction and with only very slight bleeding near the corona glandis. There remained a warty, rather hard surface, which under application of nitric acid and xeroform has been reduced to a smooth but still somewhat horny patch. This promises to disappear under this treatment. The horn measures $\frac{3}{4}$ of an inch in length and $\frac{1}{4}$ inch in width at the base, it shows a rather sharp, hook-like curve, so that over the convex surface it measures 2 inches, over the concave surface only 1 inch.

In this case the formation of the horn seems to be part of a keratosis which is restricted to the glans penis; the skin of the rest of the body does not exhibit any keratosis or ichthyosis whatever.

CHICAGO DERMATOLOGICAL SOCIETY.

April 24, 1908—Dr. James Nevins Hyde, Chairman.

Case for Diagnosis. Presented by Dr. O. S. Ormsby.

Patient, a woman aged 37 years, had had a macular, scaling eruption involving the arms, forearms, face, scalp, neck, chest, and back, with a very few spots on the lower limbs, for four weeks. The lesions had been pink; at the time of presentation they were brownish; the palms and soles were exempt. The scalp lesions were crusted; in the scalp marked itching occurred. From time to time during the four weeks there had been periods of exacerbation and quiescence; the exanthem had never disappeared, however. There was one palpable gland in the suboccipital region; no sore throat; no mucous membrane lesions anywhere, and no general symptoms. Preceding the exanthem the patient suffered with what was called "grippe," for two weeks.

The diagnosis of syphilis was agreed to by the majority of the members present.

A Case of Nail Growth. Presented by Dr. Anthony.

A man, 35 years old, was scratched on the back of the hand by a cat; following infection of the scratch a severe cellulitis, involving the

forearm and arm, developed, necessitating a number of incisions for drainage. The infection had healed when the patient was presented to the society. In the *luna* of each nail of the affected extremity there was a new nail pushing the old nail outward.

Three Cases of the Thin, Wide, Flat Finger Nails of Toxic Hyperhidrosis. Presented by Dr. ANTHONY.

The first case was a girl, 10 years old, with tuberculosis of the cervical glands and of the radius. The hands were cold, clammy and moist. There was present an extreme degree of thin, wide, flat finger nails.

The second case was a boy, 8 years old, with tuberculosis of the hip, showing the same cold, clammy, moist hands, with less marked thin, wide, flat finger nails.

The third case was a boy, 6 years old, with nasal adenoids, intermittent sweating and asphyxia of the nose. The hands were cold, clammy, and moist; the finger nails were thin, wide, and flat.

Dr. Anthony stated that he looked upon Toxic Hyperhidrosis of the hands and occasionally of the feet as a combination of hyperhidrosis and asphyxia caused by toxines derived from distant *foci* of tuberculosis and chronic pus infections such as nasal adenoids (*The Acrodermatoses of Scrofula*, JOURN. CUT. DIS., 1907, p. 241). In this condition it is not uncommon to find the finger nails flat, wide, and thin, a deformity which is not congenital.

Case of Acne. Presented by Dr. W. A. PUSEY.

A very severe indurated acne with many comedones on the upper half of the abdomen and the lower third of the chest in a man whose occupation kept his clothes saturated with grease.

Case of Leukoplakia of the Lower Lip. Presented by Dr. E. A. FISCHKIN.

The patient was 60 years of age; no history of syphilis; smokes mild cigars; duration of the affection eight months. On the vermilion border of the right side of the lower lip, was a patch, the size of a bean, of cornified epithelium. The lesion was considerably thickened especially towards the median end, where it ended in a sharp line, giving the impression of a piece of white leather cut off with a knife. The patch was stiff, firmly adherent, and not exfoliating.

Case of Tinea Sycosis. Presented by Dr. W. A. PUSEY.

Man with tinea sycosis confined to an oblong circumscribed patch one and one-half inch long in diameter on the left cheek, resembling somewhat blastomycosis.

Case of Lupus Erythematosus. Presented by Dr. Ormsby.

The patient was a man 45 years of age and the disorder of three months' duration. The eruption consisted of two dime-sized lesions, one on either side of the nose, and two smaller ones immediately beneath these. They presented erythematous margins with a beginning atrophic center; scaling was quite marked. The larger two had all the appearances of being produced by trauma from glasses.

The principal point of interest in connection with this case was the fact of the rapid development of the lesions.

Case of Mycosis Fungoides. Presented by Dr. L. Pardee.

The patient was a widow, 55 years of age; family history negative. She had been in good health previous to two years ago, at which time an eruption began as a psoriasiform patch on the right elbow; when first noticed it was about the size of a quarter. Later smaller patches appeared on the left elbow and on the legs, especially below the knees. These patches caused intense itching and discomfort, extended peripherally; became boggy to the touch, and bled easily upon slight traumatism. When shown to the society a generalized, nearly symmetrical eruption was present resembling a dry eczema in character. It was located principally upon the arms, legs, and back. The edge of the eczematoid patches were rather sharply defined and areas of apparently normal skin appeared between them. In size the lesions varied from that of a quarter to larger areas including half of the back. Upon each forearm extending from the elbow downward, half way to the wrist, were boggy, deeply infiltrated areas, reddened and slightly scaly upon the surface. One of these showed a small area in which hæmorrhages had occurred following a slight trauma. Upon one breast beneath the nipple was a slightly fungoid area about the size of a dime. The entire eruption itched intensely, but had never shown signs of any oozing. The lesions were brownish red in color and were covered with fine scales

The general condition of the patient was fair; she was able to be up and about, and other than the itching complained of nothing except a general muscular weakness which was shown in a tremor of the limbs and hands.

Ernest L. McEwen, M. D.,
Reporter.

MANHATTAN DERMATOLOGICAL SOCIETY.

65th Regular Meeting, January 10, 1908.

Dr. A. Bleiman, Presiding.

Chancre of the Rectum. By Dr. A. Bleiman.

M. C., fifteen years old, presented himself on January 10, 1908, with a fully developed universal maculo-papular syphilide, typical adenopathy and condylomata lata. Usual questions failed to bring forth the origin of the infection. Examination of the anus showed a suspicious tear along the posterior margin, which justified the exploration of the rectum. About an inch within the anal sphincter, on the posterior wall, is the typical indurated primary sclerosis. The patient then confessed to the practice of pederasty.

Chancre of the Rectum. By Dr. E. Pisko.

Martin W. W., seventeen years old, Austrian. Presented himself December 26, 1907, at the Harlem Hospital Dispensary (service of Dr. E. L. Cocks) with the following history: Three months ago noticed something growing around and within the rectum. The affected region felt sore all the time, soreness being more marked during and after defecation. One month later noticed that his lips became hard, and then cracked, and that his tongue pained him, especially while eating and during the night. Two weeks ago throat became sore and an ulcer, about 1 by $\frac{1}{2}$ inches, formed on the side of the tongue.

Examination with rectal speculum revealed a lesion with indurated edges about one and one-half inches within the anal sphincter. From the anal margin to the tuber ischii the skin is studded with moist papules varying from pinhead to pea in size. On the tongue were several mucous patches and the lesion above described by the patient. One erosion on the edge of the soft palate and two on the posterior pharyngeal wall. Marked gingivitis and general adenopathy is present.

At first the patient offered no explanation for his infection. Later confessed to the practice of pederasty and buccal coitus.

Chancre of the Rectum. By Dr. E. Pisko.

Henry H., sixteen, American, clerk. Presented himself at the Harlem Hospital Dispensary (service of Dr. Cocks) on December 28, 1907, with complaint similar to the previous case; for two and one-half months he had moist papules in the anal region, some tenderness and pain upon defecation. Examination at that time revealed an ulcer with indurated edges two inches within the sphincter, and a typical luetic angina.

Present condition: Scalp, axillæ and pubes shows a marked alopecia; tonsils show crateriform excavations with pseudomembraneous

coating; in the sulcus of the penis are two moist papules, two days' duration; recto-anal region studded with moist papules, pinhead to large pea in size; there is a general adenopathy; the right epitrochlear gland enlarged to the size of a hazel-nut.

The patient states that last fall he worked with a circus and was obliged to use the same toilet as was used by a man who was known to be sick. He absolutely denies any other source of his infection.

Both of the above patients were put on anti-syphilitic treatment January 31, 1908 (injections of salicylate of mercury), and all the lesions have cleared up.

Drs. Cocks and Gottheil believed that extra-genital infections are more common than they formerly were. Dr. Cocks recalls nine cases of extra-genital sclerosis that are now at Randall's Island.

Tuberculosis Cutis Verrucosa. By Dr. W. S. Gottheil.

Adolf H., twenty-seven, brassworker, has had his affection for six years. It began as a small warty excresence, increasing in size very slowly. Though he has more or less trouble at all times from particles of brass, etc., getting into the crevices and irritating the lesion, it is especially painful in the cold weather, when cracks and fissures appear.

Examination. Patient is a slender, delicate-looking man; looks tubercular, though nothing definite can be found in the examination of his chest. On the outer dorsal aspect of his left hand, and extending from two inches above his knuckles down onto the little finger and to base of the right finger, is a sharply outlined but irregular and markedly verrucous lesion. Around the base of the entire lesion is a narrow margin of erythematous tissue, purplish-red in color. The warty excresences are grayish to dark brown to black in color, insensitive, dry and hard, and readily removable, exposing a dark red papillary surface beneath. Deep rhagades traverse the warty growth, and contain some serum and pus.

Treatment proposed: Destruction or excision is contra-indicated on account of the location of the lesion. Actinotherapy (Finsen) would be most desirable, but the presenter has given up its use on account of its immoderate expensiveness both in time and money. Proposes to employ the X-ray. Cornell safety tube; holding this to be one of the few cases in which this treatment is indicated and allowable.

Erythema Multiforme Tuberculatum and Acute Eczema. By Dr. W. S. Gottheil.

Robert S., forty-nine, single, referred to me with the following history: Three weeks ago "lumps" appeared; in the last few days has been using a salve, and has gotten worse. Examination shows the presence of perhaps twenty nodular lesions, mostly on face and neck, with a

few on the backs of forearms and hands. These lesions are purplish, fairly sharply limited, moderately elevated; vary in size from that of a large pea to that of a small nut, and are soft. Each one has been persistent since it appeared, then grow very slowly, and no new ones have appeared in the last few days. No other symptoms the first time the presenter saw the patient. He states, however, that he had felt feverish and had rheumatic pains when the nodules first appeared. The rest of the skin is free; no adenopathy; wears a double complete denture, and has some irritation of the palate and fauces, but nothing characteristic in the throat. On the face and neck is an acute papulo-versicular eczema, probably due to the external application employed.

The opinion generally favored diagnosis of nodular syphilide. Epicrisis: Under the exhibition of full doses of sodium salicylate and an indifferent application externally, the eczema promptly disappeared and the nodules flattened out and disappeared. By the middle of February, 1908, only stains were left. No further symptoms.

M. B. Parounagian, M. D.,
Secretary.

NEW YORK ACADEMY OF MEDICINE.

Section on Dermatology

Stated meeting, held April 7, 1908.

Dr. A. R. Robinson in the chair.

Two Cases of Telangiectases (Xeroderma Pigmentosum?). Presented by Dr. Howard Fox

The patients are sisters aged 8½ and 3 years old respectively. The parents are living and healthy. There are no brothers or sisters. The grandmother is said to have been a "bleeder" and the elder of the two girls is said to bleed very profusely from insignificant wounds. The older girl suffered from bronchitis as an infant and later from a slight attack of measles. She has always been pale but in apparent good health. At times she has complained of pain in the knee. Four years ago she first noticed an eruption upon the face. This was confined to the chin, nose, and cheeks. It began in the spring and disappeared almost entirely in the fall, some of the lesions on the chin persisting. The same phenomenon was repeated during the next three years. Two years ago the spots on the back of the hands were first noticed. Examination shows a considerable number of punctuate, linear and stellate telangiectases scattered about the chin, nose, cheeks, and backs of the hands and wrists. A few lesions are seen on the backs of the fingers and on the forehead. There

is a mild eczematous condition of the lips which has existed for several months.

The younger child first presented lesions of the cheeks a year ago. In her case the lesions have persisted during the winter. The lesions are few in number. On the back of the left hand are several diffuse telangiectatic areas a centimeter or less in diameter. There are also larger ill-defined areas on the wrist and back of the forearm. The child apparently enjoys perfect health. Her lips have lately become "chapped." The lesions presented by both children disappear upon firm pressure to appear rapidly when pressure is removed.

Pityriasis Rubra Pilaris. Presented by Dr. Howard Fox

The patient was presented before the New York Dermatological Society April 24, 1906, and before the Sixth International Congress of Dermatology as a case of Pityriasis Rubra of Hebra. At that time the eruption was universal. In the discussion that followed the diagnosis of pityriasis rubra pilaris was not suggested. The patient, a girl of 13, was born in Scotland and came to America when four years old. She suffered from scarlet fever when three years old. Eight years ago she first noticed an eruption upon the palms and later upon the face, trunk and extremities. This lasted six months and then disappeared entirely. It appeared again two years later and within a month had become universal.

It has improved several times since then, never clearing up any more than at present. The general health has always been fair.

Above the waist line the eruption is universal, the skin appearing bright red and scaly, although constantly softened with vaseline. The back is covered with medium sized "pie crust" flakes. The inner aspect of the thighs, popliteal spaces, and greater portions of the legs are free, though dotted with small islands of aggregated lesions or transverse bands. These lesions have a shiny aspect as in lichen planus, and a few single lesions are flat and umbilicated. On the dorsum of the middle phalanges are groups of plugged follicles.

Xanthoma Tuberosum. Presented by Dr. Howard Fox.

The patient is presented for contrast with a case of xanthoma tuberosum, associated with diabetes (reported in Trans. of Sixth Internat. Dermatolog. Congress), and now shown again here. He is 37 years old, born in U. S., a tailor. There is no history of any disease like the present in his family. A year ago he suffered from rheumatic pains in the muscles of the shoulders. He has had one attack of jaundice which lasted about a month. Eight months ago he first noticed an eruption upon the palmar surface of the left thumb. The eruption then spread upon the palm, and within two months had attained its maximum growth. It appeared later upon the elbows, buttocks, and eyelids. The lesions have

never caused any subjective symptoms or inconvenience whatever. The eruption consists of yellowish pin-head sized and larger tubercles, aggregated in patches upon the palms and elbows. The patches upon the palms follow the natural clefts in the skin. On the buttocks the lesions are discreet. The upper lids show typical lesions of xanthoma planum. The lesions are all distinctly yellowish, showing no admixture of red. They are firm and are not tender to the touch. The urine does not contain sugar or bile pigment. There is no jaundice of the skin or mucous membranes. The patient is well nourished and apparently enjoys good health.

Discussion:

Dr. Pollitzer said that the degree of redness was of no aid in making a differential diagnosis between xanthoma tuberosum and xanthoma diabeticorum, because this feature shows all possible gradations between the extremes of the two types. Typical papules of xanthoma diabeticorum are so red, and contrast so strongly with the yellow apices, that they usually suggest pustules at the first glance. The lesions of the two diseases are the same in structure except for the slightly greater diffusion of the anatomical changes and slightly greater inflammatory reaction in xanthoma diabeticorum. In both diseases the nodules may come and go, and herein both differ from the so-called xanthoma planum, which in reality is in no way related to this disease, though both may occur in the same person. Diabetes presumably has nothing to do with the one of these cases in which it occurs, and the case is simply one of xanthoma tuberosum in a glycosuric.

Dr. Orleman Robinson said that she had under her observation and treatment a case of xanthoma tuberosum multiplex in a child of two years in which there were about one thousand lesions, the majority of which exhibit a red periphery,—a yellowish hue only appearing upon pressure, and the redness rapidly reappearing upon removal of the pressure. Repeated urinary examination showed no traces of sugar. The lesions have now entirely disappeared, leaving a pigmentation in some places. She cited this merely to show that redder lesions were present in a non-diabetic case than in the case just shown.

Dr. Lapowski said that he would like to hear reports of cases of xanthoma, giving full details of the condition of the various internal organs, with complete analysis of the urine, which might throw some light on the true nature of the disease.

Dr. Robinson said that he agreed with Dr. Lapowski that we must look to chemistry for further advance in knowledge of the etiology and pathology of xanthoma. He reported a case showing typical lesions of xanthoma diabeticorum, in which the urine was not found to contain sugar, though examined repeatedly during six months. Some time later, however, sugar appeared in the urine of this case. He did not believe there was any connection between the diabetes and the xanthoma in the case shown this evening, on account of the character and location of the lesions.

Dr. Howard Fox, closing the discussion, said that he had shown the case as one of xanthoma tuberosum coexisting with diabetes, but not as a case of xanthoma diabeticorum. The absence of tenderness and of subjective symptoms were opposed to the latter diagnosis. Furthermore, an anti-diabetic diet had no effect on the xanthoma lesions.

Verruca Seborrhoica. Presented by Dr. Robinson.

The patient is a male 48 years of age. He has suffered lately from slight pruritus and lesions of urticaria factitia can be readily produced. The case is shown on account of the number of the lesions: there must be near one thousand and new ones are continually arising. Their appearance is that of the usual seborrhoic wart. The majority are not larger in diameter than a pea. I have seen several cases in which these warts followed scratching of the skin on account of a pruritus probably the result of an endogenous toxæmia.

Discussion:

Dr. Lapowski said that he could see no connection between the seborrhœa and the warts. He had seen cases in children showing five or six hundred flat warts on the hands and face, but without seborrhœa. In this case he would not connect the old pigmented lesions with the new ones.

Dr. Pollitzer said that the verrucæ planæ referred to by Dr. Lapowski was a different condition, being a multiplication of prickle cells, with prolongation downward of rete plugs; a hyperacanthoma without hyperkeratosis. He had seen a case similar to the one presented in an old woman, which was relieved of itching by the use of a resorcin and sulphur ointment.

Pigmented Hairy Naevus. Presented by Dr. Trimble.

The patient is a girl of 18 years of age. Just under the chin, a little to the left of the middle line, was a lesion about the size of a five cent piece, black, and full of coarse black hairs. This has been treated with seven applications of liquid air. There remains now practically no scar, but only a very small pigmented spot, which can easily be removed with one more application.

Pigmented Hairy Naevus. Presented by Dr. Trimble.

The patient is a girl, 19 years of age. To the right of the middle line of the chin, just below the angle of the mouth, was a lesion about the size of a ten cent piece, of the mouse skin variety. A peculiar feature of this case was that the center, about the size of a match head, protruded about one eighth of an inch above the surface, and was of a verrucous type. Four treatments with liquid air effected a cure, there being no pigmentation left and only a very inconspicuous cicatrix.

Discussion:

Dr. Pollitzer offered his congratulations on the excellent result obtained, but protested vigorously against this method of treatment. In these cases we are dealing with epidermic inclusions, and, what is worse, with pigmented inclusions. There is no guarantee that these cells are all destroyed by this method, and a scar is formed which holds any residual epidermic cells in its meshes, and in a certain proportion of cases carcinoma will surely develop. If the lesions are too large to excise, they should be left alone.

Dr. Dana Hubbard said that he had been using liquid air for the past seven years, and in that time he had never seen epithelioma return after it had been pronounced cured by this method: neither had he seen carcinoma develop on a spot that had been treated by liquid air. This agent removes a large part of the diseased tissue, diminishing to that extent the liability to the development of carcinoma. Both liquid air and carbon dioxide snow are being daily used for the cure of carcinoma in all of its various manifestations.

Dr. Trimble, closing the discussion, said that he had not seen any carcinomatous degeneration in hairy nævi, and that he thought this complication rather unlikely, and the danger not sufficient to stop the use of such a satisfactory method of treatment. Large nævi are not amenable to operative surgery, and the X-ray, trichloracetic acid, and alcohol injections are not necessary.

Tuberculosis Cutis treated with the X-ray. Presented by Dr. Clark.

The patient is a boy 8 years old, of Irish parentage. He has always been delicate. His family history is negative, except that a sister died at 1½ years of age following measles, and is said to have had sores on her exactly like those on this patient. Two years ago the patient had measles, and directly following the attack he noticed pimples which slowly developed into scab covered sores forming around the wrists, elbows, ankles, knees, and the top of the feet. These sores have gradually increased in size up to the present time, and none of them have healed. They have not been especially painful and there is a tendency for thick heaped up scabs to form on them. The child's general health has been poor and he gives a mild positive reaction to the ophthalmo-tuberculin test with a ½% solution (Trudeau's). He catches cold easily, and has no energy or ambition, and is distinctly anæmic. The lesions are multiple, from one-half to one inch in size, irregularly circular in shape, and slightly raised above the surrounding surface. They are a dull red or bluish color, and covered in places with thick laminated adherent crusts, which when removed reveal small bleeding depressions and a surface that appears to have been formed by smaller and larger tubercles. The case is shown because of the unusual character of the tubercular lesions following measles and the effect that one X-ray exposure to some of the sores has produced as compared with various other points of treatment applied to some of the other sores. Exposures were just enough to produce a slight reaction, and surrounding inflammatory areola for a few days. This has resulted in a tendency to heal, which in most of them has gone on almost to completion. The elastic strap the boy is wearing around his neck was put there to demonstrate Bier's Stauungs Hyperæmie for tubercular glands of the neck, which the child has.

The patient is also taking iron and cod-liver oil and is kept out of doors as much as possible; and after the other sores have been X-rayed he will be sent to the country.

(*To be concluded*)

REVIEW
of
DERMATOLOGY AND SYPHILIS

Under the charge of A. D. Mewborn, M. D.

DISEASES OF THE HAIR AND NAILS.

By Frank Crozer Knowles, M. D., Philadelphia.

Etiology of Trichorrhexis Nodosa, A Note on the. H. G. Adamson. (*Brit. Jour. Derm.*, 1907, p. 99.)

Adamson first describes the theories as to the causation of this condition; the original mechanical injury theory of Erasmus Wilson, the diplococcus of Raymond, and the bacillus of Hodara. He records the history of two marked cases of this disease under his care. Many of the hairs in these patients showed whitish nodes, at the intervals of a few inches; others, however, exhibited but one or two nodes to each hair. The following conclusions were drawn in the paper: That hairs which have undergone some nutritional disturbance, from a marked pityriasis, general malnutrition, an interference with the function of the papilla, from ringworm fungus, or the prolonged action of soap and water, may, upon mechanical injury, develop a node, which under the microscope isidentical with that found in trichorrhexis nodosa. Therefore he considers the origin of the disease as a nutritional change in the hair, followed by an injury to the same.

Alopecia Areata, A New Method of Treatment in. J. J. McInerney. (*Brit. Med. Jour.*, Jan. 25, 1908.)

In a short note, a typical case of alopecia areata is described. The bald area is three inches in diameter, at the side of the occiput. A new treatment was inaugurated, consisting of painting the affected patch with a 20 per cent. solution of formaldehyde. This was continued daily until signs of inflammation appeared, then a sedative ointment was applied. Alternate stimulation with formaldehyde and soothing with a mild salve was continued for six months, at which time the hair started to reappear. The result was entirely successful in this case.

Trichopathophobia. A. D. Mewborn. (*Jour. Amer. Med. Assoc.*, Jan. 4, 1908.)

Under this euphonious title, which simply means the "fear of disease of the hair," Mewborn has written an article describing every phase of the subject. He divides the paper into several headings: Worry over the loss of the hair, either partial or complete; worry over

the color or change in color of the same; worry over changes in the hair, such as brittleness, kinkiness, lack of luster, etc.; worry over excessive growth in unusual locations, and finally, failure of the hair to grow where it usually does. The constitutional and local conditions causing either an increased growth of the hair or a loss of the same are discussed. The effect of drugs taken internally or applied locally is mentioned. He describes in conclusion the curious effect that menstruation and pregnancy may have upon hypertrichosis, and also the various forms of alopecia.

Trichonodosis. J. M. H. MacLeod. (*Brit. Jour. Derm.*, 1907, ix, 40.)

The condition had originated in a Cingalese girl, six years ago, at the age of seven. The hairs were dry, lustreless, deeply pigmented, curled up, with a nodular thickening near the end. The scalp was dry, but pityriasis and hyperkeratosis were absent. The hair was short, breaking off when it reached the shoulders. The tips of the hairs were atrophic, or frayed out. The ends split up into several pointed fibers, or were bent in a shape of a hook. The majority, however, were curled up at the ends, forming loops, consisting of a single knot or a slip-knot. A mild form of trichorrhexis nodosa was also present in some of the hairs. No pathogenic cause was discovered.

Keratosis Follicularis Associated with Alopecia Areata. MacLeod and Collins. (*Brit. Jour. Derm.*, Jan., 1908.)

Three brothers, aged respectively nineteen, thirteen and ten years of age, were exhibited for the Dermatological Section of the Royal Academy of Medicine, on December 19, 1907. All three showed plugging of the hair follicles with horny spines over certain regions of the body, most marked, however, on the face, the scalp (two cases), back of the neck, and also on the extensor surface of the arms and buttocks. This same condition was noted wherever hair follicles existed, but in a much milder form. This follicular involvement led to a loss of the eyebrows and eyelashes in all of the cases, and to an almost complete baldness in two. There was also a mild ichthyosis present. The condition appeared in two of the brothers during the first year of life, and in the third before the end of the second.

Trichorrhexis Nodosa. Arthur Whitfield. (*Brit. Jour. Derm.*, 1907, p. 54.)

The patient, a medical student, was presented at the January meeting of the Dermatological Society of London. The condition was limited to the hairs, on the posterior surface, at the border of the scalp. The typical splitting of the hair fibers was seen under the microscope. The apparent cause was the trauma from using a strong solution of carbolic acid for pustular lesions on the back of the neck.

Onychomycosis. Colcott Fox. (*Brit. Jour. Derm.*, 1907, p. 240.)

The patient, a bus-driver, forty-five years of age, was presented at the June meeting of the London Dermatological Society. The condition had originally started fourteen years previously. All of the nails on both the hands and the feet were involved. Several typical patches, of short duration, were also noted on the dorsal surface of the hands. A coarse mycelium was readily found upon microscopic examination. Symmetric involvement of the nails was commented upon as being unusual in tinea.

Pigmentation of the Nails in Secondary Syphilis. Vorner. (*Münch. Med. Wochensch.*, Dec. 10, 1907.)

Vörner records an interesting case, in which a man, of twenty-one years, after an uneventful period between the initial lesion and the secondaries, developed pigmentation of the nails at the appearance of the generalized eruption. The black spots appeared in the lunula of the finger nails, which became progressively larger from week to week. The deposit of pigment was not even or uniform. On the left hand, the fifth finger only showed this condition markedly.

Alopecia, Frontal Band, as a Possible Sign of Exopthalmic Goitre and Associated Conditions. David Walsh. (*The Lancet*, London, 1907, p. 1080.)

The frontal band type of alopecia that is described in this paper, is situated over the frontal portion of the scalp, at the anterior margin of the normal head of hair. It stretches from one frontal eminence to the other. Walsh states, that it is congenital, hereditary, and is often found in several members of a family, but more frequently on the female side. The alopecia may be of the areata type, but usually a few scattered hairs may be found in the band. The entire involved area may be thinly covered with hair, or there may be a thin pencil of hair, on one or both sides, where normally the hairy scalp would have commenced. He has found it constantly associated with the symptoms of Graves' disease.

Hypertrichosis Circumscriptum. Wilhelm Landau. (*Wiener klin. Wochenschr.*, 1907, p. 831).

A very interesting case of local hypertrichosis is described by Landau in his paper. The patient was a female twenty-three years of age, of medium size, normal masculature, and with unusually elevated shoulders. The family and personal history were both negative. The patch was situated over the spinal column, in the median line of the back, it was twenty-two centimeters in length, and six centimeters in

width. The patch was sharply marginate, with pointed extremities, and reached from mid-way between the shoulders to the lumbar region. The hair hangs down from this area like a "pig-tail," it is soft and silky, and for the first twelve centimeters is dark-brown in color; being of a lighter shade than on the other hairy parts of the body. The hair is thickest on the median line of the patch and becomes progressively thinner as the border is approached. The hair converges towards the median line and is shaped like a comb over the spinous processes. The underlying skin is normal, pigmentation, a warty growth, or atrophy being absent. The scalp hair is thick, and that on the mons veneris is normal. The downy hairs on the general surface show no unusual development. Other cases of somewhat the same character, that have been reported by other authors, are mentioned. The supposed causes of this condition are also mentioned; such as some neurosis, local irritant, or various abnormalities in the development of the individual.

Trichonodosis. Otto Kren. (*Wiener klin. Wochenschr.*, 1907, p. 916).

The source of the name "trichonodosis" is first referred to in the paper, due credit being given to the originator Galewski. Cases by other writers are then mentioned. Kren states that out of fifty-four women, who had skin disease, in whom a careful examination of the hair hair was made, in thirty-five nodes were found on the hairs. The site of the node is almost always the middle or the terminal portion of the hairs; exceptionally, however, they may be found on the hair near the scalp. These nodes are usually found upon the scalp hairs, but those of the body are not exempt. These small bodies on the hairs may be numerous or only a few may be present. Although the nodes may be seen by the unaided eye, the mieroseope is necessary to see the knots in the hair. Several varieties of knots are pictured in the paper.

Dr. Frank Hugh Montgomery
1862—1908

OBITUARY.

Frank Hugh Montgomery, the son of Albertis and Mary Louise Montgomery, was born on the 6th of January, 1862, at Fairhaven, near St. Cloud, Minnesota. His early studies were conducted in the St. Cloud High School and in the University of Minnesota. He was graduated in medicine at Rush Medical College, Chicago, in the year 1888. His post-graduate work was conducted in the Johns Hopkins Medical School, and in the hospitals of Paris, London, and Vienna. On the 11th of January, 1897, he was married to Miss Caroline L. Williamson. Three children were born to them, all surviving.

At the time of his death, Dr. Montgomery was Associate Professor of Dermatology in Rush Medical College; Dermatologist to the Presbyterian, St. Elizabeth's, and St. Anthony de Padua Hospitals; and a member of the several national, State, and local medical societies. He was an active member of the American Dermatological Association, serving a term as Vice-President, and also as Secretary for three terms, during which period he edited the Transactions of that body (1900-1902). He also served as President of the Chicago Dermatological Society, taking an active part in all its meetings from the date of its organization.

His dermatological work, aside from the production of the several editions of the Treatise on Diseases of the Skin which bears his name, has been made known to his colleagues, both in this country and abroad, by his scientific articles, each of which bears the imprint of his scholarly labor and his thorough knowledge of the literature of dermatology in all languages.

Respecting the manner of his death, the name of Frank Hugh Montgomery will always be associated in the memory of dermatologists, with that of his heroic French colleague, Henri Feulard, who perished in a similarly futile effort to save the life of his daughter, in the conflagration at the Charity Bazaar of Paris in the year 1897.

Dr. Montgomery was an expert sailor and swimmer, but on the day of his death his young son, Hamilton, and, at her request and by permission of her husband for this excursion only, Mrs. Head, his stenographer, accompanied him for a sail on White Lake, Michigan, near which was the doctor's summer home. The light racing-skiff on which they had embarked, was overturned in a sudden gust of wind and the lady was precipitated into the lake on which they were sailing, drifting rapidly away from the overturned craft. Dr. Montgomery called to her that he was going to her rescue, flung off his canvas shoes, and plunged through the water. He never reached his companion, perishing on the surface of the lake in consequence of shock, possibly due to a

blow received on the head during the capsizing of his boat. Mrs. Head was drowned. His son, having been provided with a life-preserver before the embarkation, was rescued in safety.

Dr. Montgomery's death is a distinct loss to American dermatology. He was remarkable for his acuteness as a diagnostician, his skill as a pathologist and practitioner, and his extreme thoroughness in all that he attempted. He was a singularly modest man, sweet in disposition, clean in every act of his life, charming among his friends, and greatly beloved by all who constituted his *clientèle*.

Aside from his scientific work, his intimate friends enjoyed his intense fondness for music: he was a keen critic of the manner of production of its classical works. He loved wholesome out-of-door sports, was an enthusiastic mountain-climber, and a good golfer.

The circle of his social acquaintances knew him as a model husband, a devoted father and brother, and a faithful friend.

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421B,	3.50
421C,	10.50

(ESTABLISHED 1836)

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